



Protea Medical Aid Society

Application for Membership

your health is our concern
www.proteamas.co.za

New Application	<input type="checkbox"/>
New Dependant	<input type="checkbox"/>

Name of Company	<input type="text"/>
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Inception Date	<input type="text" value="yyyy / mm / dd"/>
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Option	
Accumulator Core	<input type="checkbox"/>
Accumulator Standard	<input type="checkbox"/>
Accumulator Extended	<input type="checkbox"/>
Essential Health	<input type="checkbox"/>
Excess	<input type="checkbox"/>

BANK DETAILS

Contribution Debit Order Payments and Claim Electronic Funds Transfer

Name of Account holder		Core Contribution	R
Account Number		Other Options	
Name of Bank			R
Branch Code			R
Account Type			R
			R
			R
		Total Contribution	R
Account holder Signature			

DECLARATION

1. I, the undersigned, hereby apply for membership of Protea Medical Aid Society ("the Scheme") and agree that all answers and information contained in this application completed by me or any other person/s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless the Scheme specifically notifies me in writing of the acceptance of the risk, or on a receipt of a valid membership card.
3. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
4. I agree to familiarize myself with, and abide by the rules of the Scheme as amended from time to time and authorize the deduction from my bank account, by debit order or otherwise, by the Scheme of any monies owing to the Scheme where applicable.
5. I understand that the Scheme will not be responsible for any pre-existing conditions, unless the details are fully disclosed.
6. I undertake to notify the Scheme in the event that any alteration in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of the acceptance of the risk.
7. I irrevocably give my consent to any medical practitioner, who may possess or may come into possession of any information regarding my health and that of my dependants, to disclose this information to the Scheme's Medical Officer on the understanding that this information is strictly confidential.
8. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme.
9. In the event that I elect to contribute to the Personal Medical Savings Account I acknowledge that I may receive a maximum benefit equivalent to my cumulative contributions to this account less cumulative claims paid from this account. In the event that I receive benefits in excess of my contributions at any stage during a calendar year, I agree that this excess benefit will be deemed to be a debit against future contributions to the Personal Medical Savings Account. Any debit balance on this account may be considered due and payable to the Society as at the date on which I change to another Plan in the Society or terminate my membership of the Society, whether tendered formally or by default.
10. I agree that the co-payment on Chronic medication, in terms of the Accumulator Chronic Medicine Benefit only, be debited monthly with my contributions.
11. I hereby indemnify and hold harmless the Scheme and Administrator against any and/or claims that may result due to the use of preferred providers.
12. I agree that I may apply to change from one package to another, by completing the prescribed form before the end of September each year for inception 1 January the following year, subject to committee approval.

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the Scheme from any liability and subject my membership to immediate cancellation.

Members Signature		Date	yyyy / mm / dd
Employers Signature or Stamp		Date	yyyy / mm / dd
Brokerage Name or Broker Name		Broker Code	
Broker Signature		Date	yyyy / mm / dd